

CHILD DEVELOPMENT SERVICES (CDS) FAMILY CHILD CARE (FCC) PROVIDER APPLICATION

For use of this form, see AR 608-10, the proponent agency is DCSPER

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: Title 10, United States Code, Section 3013

PRINCIPAL PURPOSE: Information is used by DA personnel to identify potential FCC providers and services to be provided. Provide household information, background and references.

ROUTINE USES: Information provided may be released IAW the Army's blanket routine uses contained in AR 340-21.

DISCLOSURE: Disclosure of requested information is voluntary; however, if information is not provided, certification of the candidate may be denied.

NAME (Last, first, MI)	MAIDEN	NAMES FROM ALL PREVIOUS MARRIAGES	
ADDRESS (Include ZIP Code)	BIRTH DATE	SOCIAL SECURITY NUMBER	TELEPHONE
NAME OF SPONSOR (Last, first, MI)	ORGANIZATION	SOCIAL SECURITY NUMBER	
DUTY STATION			TELEPHONE
SUBMIT THIS FORM TO (Address) (Include ZIP Code)			

PROVISION OF SERVICES

HOURS AND DAYS AVAILABLE FOR CARE

MON _____ WED _____ FRI _____ SUN _____

TUES _____ THURS _____ SAT _____

NUMBER OF CHILDREN DESIRED FOR CARE

UNDER 2 YEARS _____ 2-6 YEARS _____ 6-12 YEARS _____ TOTAL _____

PLEASE ANSWER THE FOLLOWING QUESTIONS

Check One

YES NO

ARE YOU CURRENTLY CARING FOR CHILDREN

ARE YOU WILLING TO ACCEPT CHILDREN WITHOUT REGARD TO RACE, COLOR, CREED OR NATIONAL ORIGIN

ARE YOU WILLING TO ACCEPT CHILDREN FOR HOURLY CARE

ARE YOU WILLING TO ACCEPT CHILDREN FOR NIGHT CARE

ARE YOU WILLING TO ACCEPT CHILDREN FOR EXTENDED HOURS

ARE YOU WILLING TO ACCEPT CHILDREN FOR CARE DURING HOLIDAYS

ARE YOU WILLING TO ACCEPT CHILDREN FOR CARE DURING SCHOOL VACATION

ARE YOU WILLING TO ACCEPT CHILDREN FOR CARE DURING SUMMER

ARE YOU WILLING TO ACCEPT HANDICAPPED CHILDREN

ARE YOU WILLING TO ACCEPT MILDLY ILL CHILDREN

HOUSEHOLD INFORMATION (list all members of your household)

FULL NAME	SOCIAL SECURITY NUMBER	BIRTH DATE	RELATIONSHIP

HOUSEHOLD INFORMATION *(list all members of your household (Cont'd))*

FULL NAME	SOCIAL SECURITY NUMBER	BIRTH DATE	RELATIONSHIP

ARE THE MEMBERS OF YOUR HOUSEHOLD IN FAVOR OF YOU BECOMING PART OF THE

FCC HOME SYSTEM

☐ YES☐ NODO YOU HAVE INDOOR HOUSEHOLD PETS *(If yes, please list)*☐ YES☐ NO**BACKGROUND**

WHAT IS THE LAST GRADE YOU COMPLETED IN SCHOOL

HAVE YOU HAD TRAINING OR OTHER TYPES OF EXPERIENCE WHICH WILL HELP YOU AS AN FCC PROVIDER. IF YES, DESCRIBE.

☐ YES☐ NO

HAVE YOU EVER BEEN ASKED TO RESIGN OR BEEN DECERTIFIED AS A CHILD CARE PROVIDER BECAUSE OF SUBSTANTIATED ALLEGATIONS OF CHILD ABUSE OR NEGLECT. IF YES, DESCRIBE.

☐ YES☐ NOHAVE YOU OR ANY FAMILY MEMBER OR PERSON RESIDING IN THE HOME EVER BEEN CONVICTED OF ANY OFFENSE *(other than minor traffic violations)* OR ARE YOU CURRENTLY UNDER CHARGES FOR ANY VIOLATION OF LAW. IF YES, DESCRIBE.☐ YES☐ NO

ARE YOU INVOLVED IN ANY HOME BUSINESS OPERATION, I.E., SALE OF PRODUCTS, SEWING. IF YES, DESCRIBE.

☐ YES☐ NO**REFERENCES**PLEASE GIVE THE NAMES AND ADDRESSES OF THREE PERSONS *(other than relatives)* WHOM THE ARMY MAY CONTACT FOR REFERENCES. THEY SHOULD KNOW YOU PERSONALLY AND BE WILLING TO CERTIFY TO YOUR CHARACTER, ABILITY, AND EXPERIENCE.

FULL NAME	ADDRESS	TELEPHONE

STATEMENT OF APPLICATION

I hereby apply to have my home studied for certification by the Army as a provider of child care services at this installation's FCC System. I understand that in order to qualify, both I and my home must meet all standards contained in AR 608-10 and all installation requirements pertaining to the care of children. I further understand that upon my certification, the Army will refer my name to potential patrons who will then contact me directly regarding services for their children. I will not provide child care services for any child not centrally registered in the CDS Family Child Care System. I certify that, to the best of my knowledge and belief, all of my statements are true, correct, complete and made in good faith.

SIGNATURE

DATE

REQUEST FOR BACKGROUND INFORMATION AND INVESTIGATION

IAW AR608-10, USAREUR REGULATION 608-20

SUBMITTING AGENCY: CHILD, YOUTH & SCHOOL SERVICES

PRIVACY ACT STATEMENT

1. AUTHORITY: 10 U.S.C. 3013 and Executive Order 9397.
2. PURPOSE: To give permission for agencies to provide necessary clearances by examination of records.
3. ROUTINE USES: Signed consent forms will be used to screen patient medical records in order to complete clearance procedures.
4. DISCLOSURES: Giving your permission for information is voluntary; However, failure to provide information will result in denial of certification as a qualified child care provider.

TO BE COMPLETED BY APPLICANT

APPLICANT'S NAME (LAST, FIRST, MI, MAIDEN) DATE OF BIRTH

APPLICANT'S SSN

SPONSOR'S NAME

SPONSOR'S SSN

I _____ UNDERSTAND THAT IF ANY OF THE BELOW CHECKS CONTAIN ADVERSE INFORMATION, IT MAY BE GROUNDS TO DENY EMPLOYMENT AND WILL BE RELEASED TO THE SUBMITTING AGENCY. (BACKGROUND CHECKS PERFORMED ON BOTH SPOUSE AND SPONSOR REQUIRED FOR FCC)

APPLICANT'S SIGNATURE

DATE

SPONSOR'S SIGNATURE
(FCC PROSPECTIVE ONLY)

DATE

TO BE COMPLETED BY AGENCY PROVIDING INFORMATION

() DEROGATORY INFORMATION LOCATED

() NO DEROGATORY INFORMATION LOCATED

() NO INFORMATION LOCATED

AGENCY PROVIDING INFORMATION

- ☐ Alcohol and Drug Prevention
- ☐ Family Advocacy Case Management Team
- ☐ Department of Emergency Services
- ☐ Criminal Investigation Division
- ☐ Unit Commander
- ☐ Family Housing/Building Coordinator

OFFICIAL AGENCY STAMP

AGENCY OFFICIAL'S SIGNATURE

DATE